Caring For Medicare

The Challenges Ahead

SASKATCHEWAN

Commission on Medicare

Kenneth J. Fyke, Commissioner

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Caring For Medicare
The Challenges Ahead

Commission on Medicare
October 2000

The Commission on Medicare is an independent commission appointed by the Premier of Saskatchewan, the Hon. Roy Romanow, to identify the challenges facing Medicare, outline potential solutions and engage the public and health care providers in a discussion of new ideas.

If you would like additional copies of the report, or for more information:

- Visit our website www.medicare-commission.com
- Call the Commission of Medicare toll free at 1-877-494-4844
- Write to the Commission at

  P.O. Box 4766
  Regina, SK S4P 3Y4

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Foreword

Saskatchewan citizens take great pride in knowing that this province is the birthplace of the most valued social program in Canada, Medicare. Throughout much of the province's history, the development and delivery of a publicly funded and publicly administered health system has been both a struggle and a defining achievement.

No health care system will ever be perfect, but the evidence suggests that Canada has one of the best in the world. Canadians are among the healthiest people anywhere. Our health care system is widely admired for making services available to all. And the vast majority of people who receive health services are very satisfied.

Despite these facts, Canadians have lost confidence in the health care system in recent years. There are a number of reasons for that. Changes have been made to improve the delivery of health care – but the public has not always perceived it that way. For instance, when they are released from hospital just a day or two after surgery, people may think they are getting inferior care. Health care administrators, on the other hand, see shorter hospital stays as evidence of better, less invasive treatment. Health care reforms like these took place in an environment of cost cutting, creating fears that health care was being sacrificed to deficit control.

Change in the health care system has undeniably happened quickly, which has put more stress on health care workers. The concerns and criticisms of health care professionals cause the public to take notice - and to worry. Headlines about cases gone wrong, reported shortages of doctors and nurses, and issues raised by advocacy groups have all contributed to a sense of crisis.

Are there problems in our health care system? Yes. It would be surprising to find no problems in a system that is so large, so complex, and changing so quickly. The problems, however, should not overshadow the achievements of Medicare and the benefits it provides.

For the health care system to regain the confidence of the public, we need clear thinking about the goals of Medicare, the road ahead and the options for change.

Where we have been

Medicare originated in Saskatchewan as public insurance to protect people against potentially devastating medical expenses - hospital care was covered in 1947, and physician services in 1962. In 1968 the federal government passed the *Medical Care Act,* later replaced by the *Canada Health Act*. This is the legislation that articulates the five principles that apply to hospital and physician services across the country: comprehensiveness, accessibility, universality of coverage, public administration, and portability.

Since the 1960s our definition of health services has expanded beyond hospitals and doctors, and the scope of publicly-funded health care has grown to meet changing needs and expectations. As well, the concept of Medicare has evolved beyond its origins as a way to share the cost of services. Medicare is now linked to our collective understanding of social justice – what we do for one another. Our commitment to a publicly funded and publicly administered health system has become a defining characteristic of what it means to be a Canadian.

In a publicly funded, single-payer system such as ours, we agree that those of us who are wealthy cannot buy more or better health services than those of us who are not. This means that Medicare must strike a balance between what is best for all and what is best for any one individual. Medicare is designed to ensure that everyone will be treated equally – and this means that we have to decide together which services to make available, and how much of our collective wealth to devote to health care.

The challenges ahead

For the questions we are facing, there are no easy answers – there are choices that must be made. As the province that gave birth to Medicare, the people of Saskatchewan are once again being asked to look critically at what they need and expect from their health care system. To assist in finding a path for the future, Premier Romanow has asked the Commission on Medicare to identify the major challenges facing our health system today.

The challenges described here do not exhaust the list of issues. This paper is meant as a springboard for discussion, to encourage an open and forthright dialogue on the future of Medicare in Saskatchewan. A number of means will be used to further this dialogue:

A summary of this document, *Caring For Medicare: Thinking about The Challenges Ahead*, has been distributed to every household in Saskatchewan along with the questionnaire that follows this document. The questionnaire is designed not only to explore public views, but also to encourage debate about some key issues.

Over the next several weeks, health care providers and citizens will be invited to participate in forums that will link people across the province using the Saskatchewan Communications Network. The forums will reflect the issues raised in this paper, and they will focus on sharing potential solutions. These forums will assist the Commission in formulating recommendations that will be presented to government and the public for further discussion.

Individual citizens and health care organizations can also share their views directly with the Commission by writing to the Commission on Medicare, calling 1-877-494-4844 toll free, or visiting our website: www.medicare-commission.com

Please consider this paper not as the last word, but as a first step toward finding the solutions we need to strengthen Medicare for the future.

The Commission on Medicare
Kenneth J. Fyke, Commissioner
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CHALLENGE #1:

Everyday Services

"Will health services be there when I need them?"

When the baby has chickenpox, someone's injured on the farm, or Grandmother needs home care, everyday health services must be close at hand — 24 hours a day, seven days a week.

"Contrary to what they anticipated [prior to the closing of 52 rural hospitals] 89 per cent of residents reported that the funding cuts had no effect on their personal health ...[However] residents in these communities...remain concerned about access to physician and emergency services. Many communities continue to struggle with changes to health care delivery."

Health Services Utilization and Research Commission, *Assessing the Impact of Acute Care Funding Cuts to Rural Saskatchewan Hospitals*, September 1999.

In Saskatchewan, and across the country, people are concerned whether health services will be there when they need them. Throughout our lives, we want services nearby to meet everyday health needs:

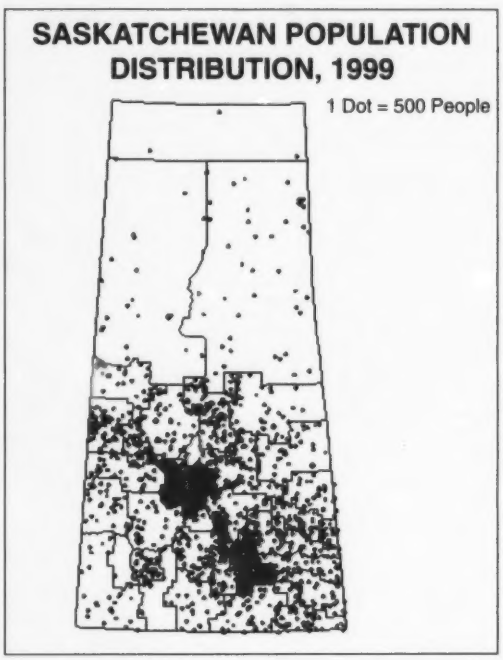
- regular check-ups and advice;
- immunization against preventable diseases such as childhood illnesses and influenza;
- monitoring the safety of water, housing and food;
- early detection of hearing and vision problems, tuberculosis or cancers;
- help in managing chronic conditions such as diabetes, asthma or schizophrenia;
- quick response in case of injury, heart attack or other emergencies;
- help at home when recovering from illness or coping with disability; and,
- support for seniors and younger disabled persons to stay independent in their homes, day programs, and respite services and residential care options.

It used to be that people turned to their local doctor to meet nearly all their health needs. And even before Medicare, people banded together to build community hospitals so they could get care close to home. Families played a big part too, and it was not unusual for several generations to live together sharing care responsibilities for children, the elderly and the sick.

Over time the range of basic services has grown, and in recent years health districts have been established to coordinate these services and make them accessible to all. Public health, ambulance services, nursing homes, home care, community therapy and mental services all play a part in meeting the health needs of communities today.

Recruiting and keeping local doctors and other care providers has always been a challenge for small communities. Many tales are told about that legendary class of hero – the tireless small town doctor. Today, the expanded range of services means that more kinds of professionals are needed. Supply has not kept pace with demand for nurses and other skilled staff. With many communities getting smaller, they face a big challenge in providing the full range of services people need.

Many rural people travel long distances for services from groceries to tractor parts and entertainment. People travel to get health care too, but local services are still seen as essential. Emergencies can happen at any time. Seniors may not be able to travel. Ongoing support is required for people to manage mental health needs or addictions. And people with chronic disease or disability need continuing care.



Discussions about community health services tend to get stuck on the question of keeping hospitals open. The real issue is not hospital buildings, but people who provide services. The old model doesn't work any more—a single physician, working alone cannot meet the needs of the community 24 hours a day, seven days a week. Nor can enough professionals be gathered in each and every town to answer to people's needs.

People living in cities have more options for everyday health care, but still may not know where to turn when complex problems leave them bouncing from one service to another. When a child has a fever in the middle of the night, many don't know who to call and end up in hospital emergency line-ups.

To find a model for everyday services that will work for the future, there are many questions to explore. How can services be shared between communities? Could the telephone be used to get more health care advice? Could a team approach coordinate services to meet complex needs? When is it possible for people to travel to services, and when is it better to have care providers travel to people? Should emergencies be handled in a small hospital, or is it better to stabilize and transport the injured or sick by ambulance, and treat them in a larger hospital?

Current situation

Since the inception of health districts, a great deal has been done to strengthen community service delivery. District boards find it is difficult to develop community services to their fullest when public pressure is focused on keeping hospitals open at any cost. While hospital

Did you know?

An estimated 15% of ambulance calls are for life threatening emergencies. Remaining calls are for routine transfer between facilities and other non-emergency health needs.

Source: Health Services and Utilization Research Commission, *Reducing Non-Urgent Use of the Emergency Department: A Review of Strategies and Guide for Future Research.* 1997.

Did you know?

Saskatchewan has 118 publicly funded nursing home beds per thousand residents aged 75 and over. The national average is 108 beds per thousand.

Source: Saskatchewan Health

care should be available when needed, there is a range of other services that can help meet everyday needs close to home.

Emergency Services

Emergency services at their best are vital life-saving services that do much more than simply transport people to a hospital. Highly trained emergency care providers such as Emergency Medical Technicians or Paramedics are specifically prepared for the tasks of assessment, treatment and stabilization that are so critical in emergency situations.

About 90 per cent of the Saskatchewan population lives within 30 minutes of an ambulance service, although few of these operate 24 hours a day. There is a wide variation among communities in the level of training and wage rates for emergency staff. Although there have been upgrades, many ambulances are in need of replacement. Response times, integration with other district services and charges to the public also vary greatly across the province. Ambulance use is difficult to coordinate, with empty ambulances sometimes passing each other as they travel between smaller centers and major hospitals.

Public Health Services

Public health works to protect health, prevent disease and injury, and promote health of individuals and the community. Public health professionals keep epidemics in check, and ensure the safety of food and water. They work with communities to identify and address health concerns, and serve as a link to other programs and services. Public health measures like immunizations for flu have been very successful in reducing pressure on treatment services.

Long-term Care Services

People who use long term care include those with disabilities due to illness, age, or chronic conditions. Evidence shows that most people are better off living in the community, supported by home care and community services, rather than in institutions. Assessment by district staff is used to determine the need for home care or nursing home placement. In spite of efforts to improve assessment methods, family and physicians do not always agree with these assessments.

Saskatchewan still has a higher than average number of institutional nursing home beds compared to other provinces. Many nursing homes were built years ago, and may no longer meet today's needs. Some are too far away from the families of residents, or in towns with poor access to hospitals and other services. Some nursing homes were constructed for a style of care that is no longer acceptable. A number of buildings are deteriorating. Elderly people and younger persons with disabilities need a high standard of residential care that allows them to participate and be part of the larger community.

Community Health Services and Home Care

Home care programs have increased significantly in scope since the formation of health districts. The volume of service has gone up by 61 per cent in the last six years, and yet there are pressures to provide more. Many services that used to be offered in small hospitals are now provided at home or in the community. Post-hospital recovery, rehabilitation for people with acquired brain injury, intravenous therapy and home dialysis are a few examples. Initially home care was designed to serve the frail elderly and delay the need for nursing homes. Today home care also provides services to young disabled adults and children with serious medical conditions, as well as palliative care for the dying.

Mary's family doctor recently told her that she has diabetes, and referred her to a variety of health professionals for assistance. The doctor gave Mary written information from his pamphlet file but she is not a good reader. She was terrified about what lay ahead for her with the diagnosis of diabetes. Her mother had the disease and was completely blind and had lost a leg.

Mary went to all of the appointments her doctor arranged, in two communities with four different professionals. At each appointment she was asked the same questions over again. They did not seem to know about the work of the others. Mary received good advice on diet and how to manage her medication, but she wonders how she will afford to follow the course of treatment. Mary wishes there could be one person who could help her through the maze of new services she needs.

Studies by the Saskatchewan Health Utilization and Research Commission (HSURC) have shown that in many cases home care is a preferred and cost-effective alternative to hospital care. These studies also demonstrate that there are still many people in hospital beds whose needs could be met at home. A recent study suggested that in some cases home care may increase dependency and isolation, and group housing may be a better way to meet some needs.

Consumers and family members have raised concerns with the level of community support available for people with mental illness. With the reduction of acute mental health care beds there is increased pressure on mental health community support. Although community housing options have increased, there is a need for more supports and resources to help family members care for mentally ill relatives.

What is a Primary Health Services team?

- The team may include nurse practitioners trained to treat common health problems.
- Other team members would be physicians, nutritionists, pharmacists, therapist, or social workers.
- Team members could serve more than one community.

Primary Health Care

Primary Health Care is the first line of health care – the door to the services we need. In Saskatchewan, this can mean contacting a family physician, a public health nurse, or a pharmacist. A system of primary care can do more than treat people for a specific illness. Primary care can help coordinate multiple services, as well as identify and prevent health problems. As an example, to prevent diabetes reaching the point where surgery and strong drugs are needed, primary care offers counselling, diet, and ongoing management of the disease.

Nearly every province has been exploring ways to strengthen primary care. In Saskatchewan over 73,000 people now have access to Primary Health Services teams that include nurses working in an expanded role. These nurses work with a team that includes physicians and other professionals to provide a greater range of services than can generally be offered by physicians alone.

A team approach to Primary Health Services allows each health care provider – physician, nurse, nutritionist or addiction worker— to focus on what they are trained to do best. And the team approach makes it easier to develop a care plan that brings together all the services a person needs. A team practice also allows someone to be on call 24 hours a day, 7 days a week. In smaller locations, all of the team members may not be local residents, but they are able to work together whenever needed.

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Community Health Services and Home Care

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What has been suggested:

Many people believe the best way to meet community needs is to **keep hospitals open** and **recruit more physicians**. Others would not mind travelling farther for some services if they could rely on **faster emergency response, upgraded ambulances**, and more trained Emergency Medical Technicians (EMTs). **Standardized ambulance fees** across the province would improve fairness. **Transportation services** could help seniors get to nearby communities for care.

The Canadian Medical Association has called for **training more physicians and reducing tuition costs**. Others point out that working to **retain the professionals we already train** is better than training more people who may leave the country to work.

A number of provinces are exploring new models for everyday health services, with **several providers working together as a Primary Health Services team**. This is being tried now in some Saskatchewan cities and towns. Bringing together these teams could mean changing the way professionals are trained, licensed, and paid.

There are people who believe that more nursing homes, home care and supportive **housing** are needed to reduce the burden on family caregivers. Others believe that supporting the needs of seniors is a **responsibility to be shared by families** and communities as well as the health system.

Some call for **more nursing homes** to ensure that seniors can always get a bed in their own community. Others prefer the quality of larger facilities that offer **programs for dementia** and other special needs. And most want to reserve **institutional care as a last resort** when other options just don't work.

Finally, some people have argued that **a smaller number of health districts** would serve to pool scarce professional resources, better coordinate front line services and reduce administrative costs. Others believe that **keeping the current number of districts** protects the interests of small communities. Some say the real issue is not the number of districts but the fact that the provincial government actually makes most decisions, and that **districts should have more autonomy** to make necessary changes.

What do you think? Can you identify other options? It may also help to think about some of the following questions.

1. Residents of rural Saskatchewan have higher personal costs when they have to travel to get health services. Travel and accommodation expenses can be a burden, especially for those with chronic condidtions who need to travel often. Is it acceptable for individuals to cover these costs? Are there ways to reduce the burden?
2. How should decisions be made about the distribution and location of health services? Should each district have a uniform approach to services based on residents – such as a fixed number of long term care beds relative to residents aged 75 and over? Or should services be based on the number of people who actually use the services in the district?
3. Physicians, nurses, pharmacists and other health care providers are self-regulated, enforcing their own standards and defining their roles. How does this independence affect the planning and delivery of services? Are there ways to encourage more teamwork among different professionals?

CHALLENGE #2:

Specialized Care

"How can everyone get timely, high quality diagnosis and treatment, no matter where they live?"

When a health problem is serious, we all want the best skilled professionals, with up-to-date knowledge and equipment. How far must people travel to get the quality of care they need? And how long is it safe to wait?

Did you know?

A surgical program, available around the clock to do things like removing an appendix, would generally have:

- Three general surgeons
- A pathologist to help in diagnosis
- A radiologist to read x-rays and tests
- Nurses for the operating room and recovery after surgery
- Blood supply, heart monitors and other equipment

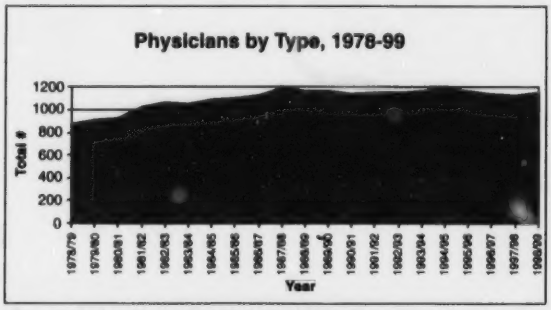
Most people in a community have basic health concerns they could take to a nurse or family doctor. Some people require more specialized services to cure or manage serious illness. When a health problem is complex or rare, people need skilled professionals who have handled many cases just like theirs. To get this experience, specialists must work in larger centres.

Some specialized services can be provided in mid-sized centres, but there are limits. A specialized service requires expensive equipment and a group of highly trained professionals.

The number of specialist physicians in Saskatchewan has grown faster than the number of physicians overall. Still, it is a challenge to recruit and retain physicians, nurses, and others with special skills. Many are in demand across the country and internationally. As medical advances continue and specialization grows, so will the challenge of training and recruitment.

Waiting to see specialists, and get tests and surgeries is a big concern for the public and physicians. In emergencies, services are provided right away, and in the majority of non-urgent cases people get services within an appropriate amount of time. However, some people wait too long.

Increasing regional services, and adding more specialists, nurses, equipment, and beds have been put forward as the obvious way to shorten waiting lists. In fact the opposite appears to be true. As the number of surgeries and tests goes up, waiting lists keep getting longer.



Source: Saskatchewan Health Annual Report.

Physicians, nurses, and diagnosticians are working very hard to meet the increased demand – resulting in long hours, increased pressure, and stressful working conditions. Staff shortages only make the problems worse.

Instead of doing more surgeries in more towns, it may be better to do less. Saskatchewan people currently receive more surgery than people in other provinces, and it is not clear that there is a reason for this. Health experts believe that the structure of the system may be biased toward providing more of some services than are actually needed – particularly when providers are paid for the volume of services they perform.

Current Situation

Distribution of Services

Nearly 50 per cent of Saskatchewan people live in or near Regina or Saskatoon. Almost 80 per cent of surgical beds and 75 per cent of all specialists are concentrated in the two largest cities. Beds designated for other specialized care (e.g. critical care, burn care, intensive care) are concentrated in Saskatoon, Regina, and the mid-sized centres like Prince Albert and Moose Jaw. Saskatchewan has increased its investment in equipment like MRIs and CAT scans, located primarily in Regina and Saskatoon.

People with rare and very specialized needs (for example bone marrow transplants) must go out of province for treatment. For some things, such as pediatric cardiology, Saskatchewan attracts patients from other provinces. Although medical costs are covered, people face financial hardship when they must travel out of province for treatment.

Did you know?

In 1998/99 there were 12,226 births in Saskatchewan hospitals; 67% in Regina, Saskatoon and Prince Albert hospitals and 23% in seven other hospitals. Nine hospitals had fewer than 20 births each in that year and 19 had fewer than 10 births.

Source: Saskatchewan Health

Regional hospitals do general surgery (for example appendix removal or hernia repair), deliver babies and have intensive care units. They also provide various other services depending on the specialists available. Even when services are offered locally, residents often bypass their regional hospitals for service in Regina and Saskatoon. For example, up to 30% of Prince Albert general surgery for Prince Albert residents is delivered in Saskatoon, even though Prince Albert has a full complement of general surgeons. Even for uncomplicated childbirth, many people go to larger centres.

There are other things being done to make services accessible, including satellite renal dialysis, chemotherapy outreach, CT scan services shared between Moose Jaw and Swift Current, and Telehealth to link people to specialists using videoconferencing and the Internet.

Surgeries and waiting lists

Hospital beds across the country have been reduced as new surgical techniques and more home care have allowed shorter and fewer hospital stays. In Saskatchewan, acute care beds have been reduced over a number of years.

Staffed Hospital Beds in Saskatchewan

Year									
Beds	5800	5304	4636	3937	3591	3282	3117	3078	2953
Reduction		8.6%	12.6%	15.1%	8.8%	8.6%	5.0%	1.3%	4.0%

Source: Saskatchewan Health, as reported by districts

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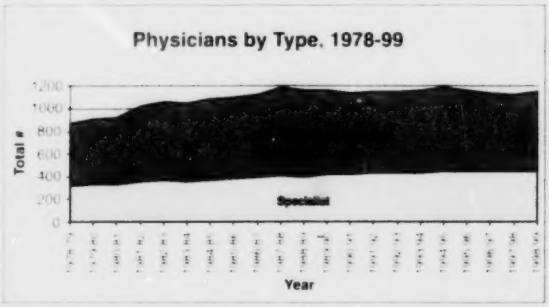

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Source: Saskatchewan Health, as reported by districts

Although the number of beds has been reduced, volumes of surgery have increased, particularly in high-demand specialties:

Increase in Surgical Procedures 1989 – 1999

Procedure	1988-89	1998-99	% Increase
Hip and knee Replacements	1,093	1,751	60%
Cataracts	3,613	11,280	212%
Angioplasties	216	901	317%
ALL SURGERIES	**76,220**	**93,802**	**23%**

Source: Saskatchewan Health

Did you know?

- For 13 out of 16 common types of surgery, Saskatchewan rates of surgery per person exceed the national average.
- Saskatchewan has one of the highest rates of cataract surgery in the country — and long waiting list to do more

Sources: Canadian Institute for Health Information, Hospital Morbidty Database; HealthService Utilization and Research Commission, *Cataract Surgery in Saskatchewan*, 1995.

On a per capita basis, physicians in Saskatchewan perform a high number of surgeries compared to other provinces. For 13 out of 16 common procedures, our rates exceed the national average, even when adjusted to reflect the age of the population. This is true for procedures with long waiting lists, like cataract surgery.

Tests and surgeries are provided right away in emergencies. Urgent procedures such as cancer surgeries are provided within weeks, according to accepted timeframes. Some waits are too long, nearly always for elective surgeries – those classified as necessary but not urgent. Most cases of long waits are for cataract surgery or hip and knee replacement. Within the elective category, cases are generally managed on a first-come, first served basis. Some physicians have much longer waits than others. Work is just begining to develop protocols to priorize patients by need. These protocols, developed with physicians, would ensure that all persons on a waiting list meet standard criteria for need, as well as ranking the level of need between patients.

Workplace concerns

Health professionals in Saskatchewan are highly skilled and valued by the public. But in both community settings and urban hospitals there is discontent with stressful work environments, long hours and lack of teamwork. The role of hospitals has changed. People in hospital are now sicker and require more care, increasing pressure on staff. Many people, but particularly nurses in acute care facilities, work overtime because of staffing shortages.

Did you know?

Because a nurse cannot be available all day every day…to fill one nursing position 24 hours a day seven days a week, requires hiring 5.4 nurses

Source: Saskatoon Health District

Stressful work environments are a concern both for quality of care and morale. Without improvement, many groups say that these issues will keep people from choosing the health care field, making staff shortages worse.

What has been suggested:

Some residents want **easier access by adding more specialized services in regional hospitals**. Others think that getting the best **quality of services** requires **centralizing specialty services** in Saskatoon and Regina where professionals have a larger population to work with. For some highly specialized services, it may be best if **Western Canadian provinces cooperate to develop Centres of Excellence** in selected cities to serve several provinces.

To attract and keep specialist physicians and skilled nursing staff, some argue that **higher salaries** are the key. Others say that **better workplace planning** is needed to support workers facing rapid change and increased demands. **Reduced overtime and more full time jobs** are also cited as ways to **recruit more nurses**.

To address waiting times, physicians groups have called for **increased numbers of beds, more operating rooms, and improved equipment.** Others point to the need to **develop standards based on research and clinical evidence** so that surgeries and tests are provided only when needed and people waiting would be assigned priority based on need.

Yvonne is an active 72-year-old retired business college instructor. She used to play tennis regularly. About two years ago arthritis attacked her right hip and now she can no longer play tennis or even walk very far without pain. The Orthopedic surgeon has put Yvonne's name on the elective surgery waiting list but cautioned her that it could be up to 18 months before she can have the surgery to replace her hip. Yvonne is a good candidate for the surgery as she is in good health and able to participate in therapy afterwards to get her new hip functioning well. Yvonne wonders how the waiting list works. Is her waiting time influenced by her age? Would she have a shorter waiting time if she changed physicians? Who would she call to find out?

Individuals who are waiting for surgery say they would like **more information** about their risks and where they can turn if they're worried about the health effects of waiting. The Cardiac Care network in Ontario and the government of British Columbia **publish waiting list information** so people know which surgeons have the shortest wait.

What do you think? Can you identify other options? It may also help to think about some of the following questions.

1. What is more important: Planning services in the way that helps recruit the best specialists, or planning based on limiting the need for citizens to travel?
2. What should be the criteria for waiting lists? Severity of the problem? Probability that the procedure or surgery will help? First come first served?
3. Would it make better use of resources to train professionals and offer some services on a regional basis that includes the Western Provinces? Even if this means more travel for patients and their families?

Although the number of beds has been reduced, volumes of surgery have increased, particularly in high-demand specialties:

Increase in Surgical Procedures 1989 – 1999

Procedure	1988-89	1998-99	% Increase
Hip and knee Replacements	1,093	1,751	60%
Cataracts	3,613	11,280	212%
Angioplasties	216	901	317%
ALL SURGERIES	**76,220**	**93,802**	**23%**

Source: Saskatchewan Health

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CHALLENGE #3:

Making Things Fair

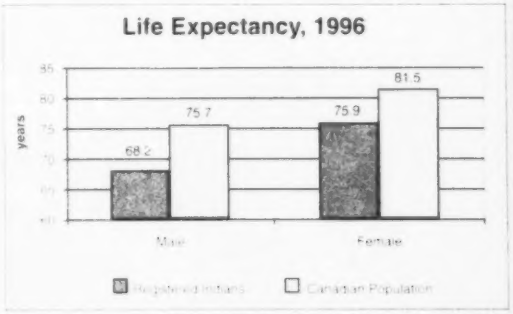
"Does the health system work for everyone?"

Even when health services are available to all, some people are more likely to have poor health. We need to get at the root of the problem, to give everyone a fair chance at good health.

"It is clear that inequalities account for differences in health status so that the poorest and the least powerful experience worse health."
Source: World Health Organization, *Population Health – Putting Concepts Into Action*, August 1998.

There are many *determinants of health* that affect overall health:

- Heredity and genetic endowment
- Healthy child development
- Income and socioeconomic status
- Education
- Social support networks
- Employment and working conditions
- Physical environments
- Health services
- Personal health practices and coping skills



Source: Indian and Northern Affairs Canada, *Comparison of Social Conditions, 1981 and 1996*

These influences affect not only individuals, but groups as well. For instance, while First Nations and Métis populations have lower rates of cancer and other diseases they experience higher rates of certain illnesses and lower life expectancy, often linked to lack of employment opportunities and poor living conditions. Seniors have higher need of health services due to health effects of aging. Children living in poverty are at risk of poorer health throughout their lives.

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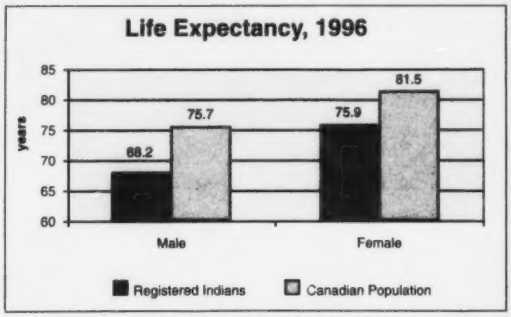

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It is important to address the underlying cause of health problems, as well as treating individuals when they're sick. For instance, improved nutrition can reduce obesity and diabetes. Better housing can reduce infections and falls. Education can lead to better employment, reducing the risk of addictions or depression.

Medicare helps make services available to all, but there are still barriers of distance, culture and language that prevent equal access. Not only are Aboriginal people more likely to get diabetes, they are also more likely than other diabetics to have complications such as amputation of a leg. For Northern residents, distance from services may help explain why fewer receive prenatal care. Divided jurisdiction over First Nations health makes it more difficult to coordinate care on and off reserves.

Most parts of our health system are designed to treat people when they are sick, rather than prevent health problems at the outset. Our system pays physicians and other health care providers for individual diagnosis and treatment, rather than for working proactively to improve health.

Measures to improve the overall health of populations often go beyond the traditional roles of doctors, hospitals and health agencies. These efforts may involve education programs, community development, housing, recreation and job creation, as well as health services.

The Current Situation

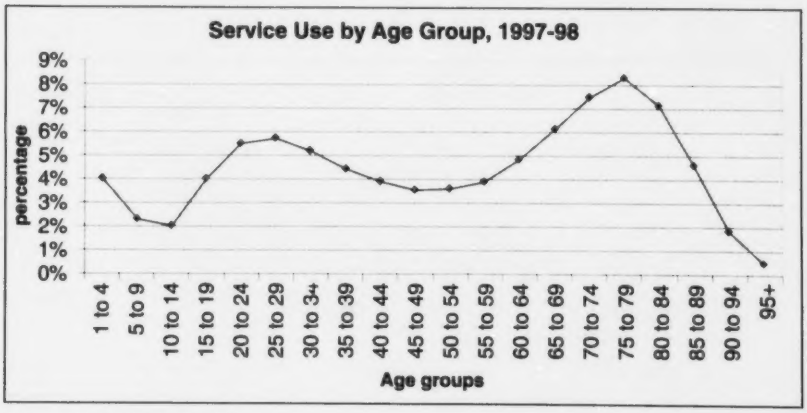
First Nations and Métis Populations

First Nations and Métis populations are younger than the total population. This age profile means that the needs of these populations, and the opportunities to improve their health, differ from those of the rest of the population.

Any effort to improve the situation of Aboriginal people needs to take into account their cultural beliefs and values and traditional views of the world and ensure that the affected groups are full participants in the development of programs and services.

The Seniors Population

> *"Getting older doesn't automatically mean high health care costs. It is illness and dying, not aging itself that is associated with higher costs."*
> Michael M. Rachlis, *Modernizing Medicare for the Twenty-first Century, (2000).*



Source: Saskatchewan Health

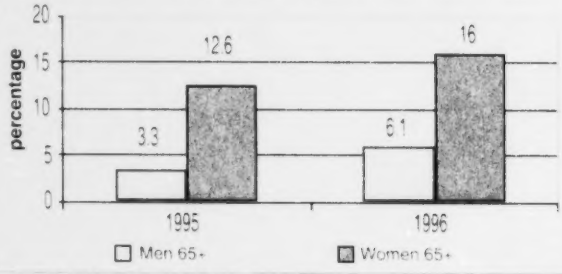
The Saskatchewan population 65 years of age and older has grown both in absolute numbers and as a percentage of the total population between 1996 and 1999. Numbers of seniors will begin to increase rapidly after 2010.

Growing old is not an illness, nor do all elderly people develop health problems. However, the older population is more likely to suffer from chronic conditions and disabilities. Health care services in the final stages of life, including nursing home and hospital care, often represent a significant share of a person's lifetime health care use.

Saskatchewan has the highest percentage of seniors of any province and this proportion is slowly growing. Even taking into account the higher number of older persons, Saskatchewan also has relatively high numbers of nursing home beds compared to other provinces. Saskatchewan has 118 nursing home beds per thousand people over age 75, compared to a national average of 108 per thousand. Senior citizens, especially women, are more likely to be poor than younger residents. Seniors who live in poverty are twice as likely to be institutionalized.

Improving the health of seniors could bring improved quality of life and reduce dependency. Chronic conditions could be managed better, falls and injuries could be prevented, and social isolation reduced.

Poverty Rates for Men and Women 65 and Older in Saskatchewan, 1995 and 1996



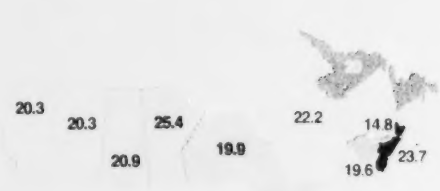
Source: Saskatchewan Health

Children in Poverty

> *"Studies in neurobiology have now confirmed that when optimal conditions for a child's development are provided in the period between conception and age 5, the brain develops in a way that has positive outcomes for a lifetime."*
> Health Canada, *Toward a Healthy Future: Second Report on the Health of Canadians* (1999)

Infants born into poverty are at increased risk for infant death and low birth weight. Children who live in poverty are more likely to suffer developmental delays. They also have higher rates of injuries. Children of parents with a low level of education are more likely to perceive their own health as poor and are less likely to enjoy good health throughout their lives. In 1996 in Saskatchewan, in one in every five children under the age of 18 lived in poverty.

Children Under 18 Living in Proverty, 1996 (in percentages)



Source: Saskatchewan Health, *Key Health Indicators*

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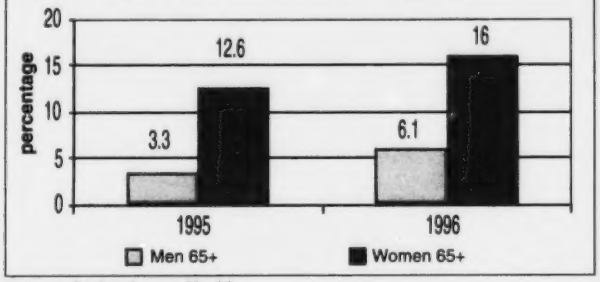

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What has been suggested:

To identify and address health problems before they start, some people say we should **change the delivery of basic health services**. They advocate **expanded group practices** that encompass not only physicians, but also nurse practitioners, mental health counsellors, or rehabilitation therapists.

There are also many people who feel that **services targeted** to specific population groups would provide better quality care. For example, **seniors' health centres** in Edmonton concentrate on meeting the total needs of their clients from housing to counselling. Others feel that we should **stick to basic services** like physicians and hospitals.

Many people believe that to improve health over the long term we could **increase investments in education, supportive housing, income assistance and early childhood programs**.

What do you think? Can you identify other options? It may also help to think about some of the following questions.

1. Should our health system be designed to reach out to populations with higher risks? Or should we concentrate on treating each individual for the problems they have?
2. What is the appropriate role of the Federal and Provincial Governments and First Nations themselves in the delivery of health care?
3. Should a greater investment be made to improve health status through means outside of the health system, such as education, housing and employment? Even if this means slowing the rate of growth of direct spending on health care or increasing taxes?

CHALLENGE #4:

Getting Results

"How do we know we're making the right choices?"

We are all responsible for decisions about health and health care — as individuals, phsicians, care providers, administrators or politicians. None of us can make good decisions unless we have the facts

> *We can't improve the health system unless we know who is accountable to whom and for what. If we are clear on what is expected, who is responsible and who is accountable, we can assess performance and results. And we can take the necessary steps to improve results.*
> (Government of Alberta. *Who is accountable in health?* August 1999)

It's often been said that the health system is not really a system at all. It is a collection of organizations and individuals all responsible for different things. Governments set overall goals and budgets. Health districts provide facilities and programs. Decisions about care are made by physicians, nurses and other care providers, according to standards set by professionals themselves.

There is not enough information about how all these decisions affect our health. The information we do have is generally not geared to evaluation. We may know the number and type of services provided, but that does not tell us whether health has been improved.

Collecting information about the health of each individual and the services they receive would help providers make more informed decisions about care. It would also provide a basis for policy evaluation. Each province has been working to develop some sort of Electronic Health Record – in Saskatchewan, through the Saskatchewan Health Information Network (SHIN). Efforts like these are sometimes criticized for using money that could go directly toward care.

Responsibility for decisions made is not always clear. A survey of district boards, and Saskatchewan Health officials in 1997 found a lack of agreement on lines of responsibility. More recently, the Saskatchewan Association of Health Organizations (SAHO), which represents the 32 health districts, has raised concerns about the process by which district health plans were approved by the Province. SAHO says that districts have not been allowed to make the decisions required to provide quality services and balance their budgets. When the provincial government decides on funding and has the last word on district plans, yet

What do you think?

"...those who provide services and manage the health system should be able to demonstrate that services and programs have improved health beyond that which would have been achieved by doing something else with the same resources, or by doing nothing at all."

districts are responsible for actually delivering services, the public is left wondering who is responsible for what.

What about the accountability of other health care providers? In industry, quality is measured by consistency. The idea is to set one standard and ensure that every unit of product meets it. In health care, this should mean doing the same thing for people in the same circumstances. That is, patients with the same condition should receive the same diagnosis and treatment unless there are clear reasons for doing things differently. But this is often not the case.

Bill and Mary have been trying for four years to have a child. They have finally conceived and are anxious to know whether the baby is a boy or a girl. The couple is fully expecting to be booked for a fetal ultrasound soon. Everything they have read indicated that this happens as a matter of course and they are looking forward to it. However, when their doctor says there is no medical reason for an ultrasound, Bill and Mary consider changing obstetricians.

For instance, research from the Canadian Institute for Health Information shows a wide variation between provinces in rates of common surgeries. Different regions of Saskatchewan have different rates of cataract removal. The World Health Organization (WHO) recommends that no more than 10 to 15 per cent of births should require Caesarian section. Canada has exceeded the WHO recommendation for the past 20 years. The rate varies across the country from a low of 12 percent to a high of over 27 percent. Why do people get treated differently in different places? What level of services is the right one?

Decision makers at all levels of the health care system want to make choices about clinical services that help individual patients, or policy decisions that will improve overall population health. However, in many cases decision makers do not have the evidence they need. When a drug or procedure offers a very small improvement, it is hard to determine if the benefits are worth the cost.

Without the benefit of good data, decisions can too easily be swayed by the pressure of private interests, like drug companies, or advocacy groups who lobby for drug approvals or more spending for specific conditions. Physicians report growing pressure from consumers who want to try tests or drugs they've heard about through advertising or word-of-mouth.

The decision-making challenge becomes greater as more drugs and technologies come on stream. There are more and more treatment options to choose from. If we don't have the information we need to make good choices and just use all the options available, the costs will be too great no matter who pays.

Current Situation

A number of agencies and organizations are engaged in research and information collection but there is no overall strategy for its use. The Canadian Institute for Health Information (CIHI) collects and disseminates health information throughout Canada including an annual report on health care with some comparative information.

In Saskatchewan, the Health Services Utilisation and Research Commission (HSURC) conducts research on Saskatchewan's health system and provides support for other health-related research. They evaluate programs and suggest clinical practice guidelines. The use of these guidelines is voluntary.

Saskatchewan Health has developed health indicators to assist districts in evaluating services for key population groups. Public agencies are cooperating on a Saskatchewan Population Health Status and Dynamics Survey to investigate health status across the province.

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providers and researchers who are working to establish guidelines that would help physicians establish relative need and priorize patients based on clinical standards.

The Saskatchewan Health Information Network (SHIN) has been working toward an Electronic Health Record, although additional investment in this direction is required. A portion of the additional Federal funding recently announced has been earmarked for Information Technology.

What has been suggested:

Many individuals are content to **rely on providers' professional judgement** to make health care decisions. Health researchers point to the need to **collect better information about which health services work best** and hold physicians, districts, and governments accountable for using that evidence. Tying funding to performance might enforce accountability.

The Canadian Medical Association has urged governments to invest new funds in the **development of a secure Electronic Health Record,** which they say would reduce costs and improve the outcome of patient care. Some people say this so important we should **use any new money from the Federal Government** to enhance information systems.

The federal government is promoting the idea of **health system report cards**. Other jurisdictions are considering report cards to give consumers **information on the performance of individual service providers**.

What do you think? Can you identify other options? It may also help to think about some of the following questions.

1. Do you think the development of information systems should be a priority for health care in Saskatchewan? Even if this means slower growth in spending on front-line care?
2. Are providers responsible only for securing the best possible care for each patient, or should they also be responsible for making the best use of resources by offering only the care that is necessary and effective? Does the fee-for-service system encourage physicians to consider cost-effectiveness?
3. Does tying physician or district funding to performance seem reasonable? Would this interfere too much with the professional autonomy of care providers?

CHALLENGE #5:

Paying the Bills

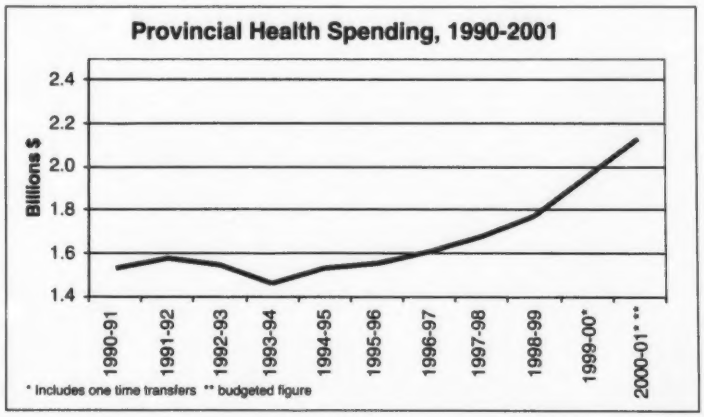
"How much should we spend, and how do we pay?"

It's hard to put a price tag on health – but every dollar spent on health care cannot be spent on education, road or tax relief. The health services we want must be paid for, whether through taxes or by individuals

"Money, specifically the lack of it, may not be what's wrong with our health-care system ...while extra money always helps, the aches and pains in our health-care system may have been better cured by radical reform."
Richard Gwynn, *Toronto Star*, September 13, 2000

There is an ongoing debate as to whether the health system has sufficient money to meet the needs of residents. On the one hand, Canadian health care spending is high in comparison to most other countries. On the other hand, there are continuing media reports of an impending health crisis caused by spending cuts and chronic under funding.

Although many believe that cutbacks have caused a crisis in health, provincial funding for health care has increased steadily since 1993/94. Provincial health spending has grown faster than other government programs, although it has not kept pace with growth in the economy.



Source: Saskatchewan Department of Finance, 2000

Did you know?

American's yearly expenditure on medical care works out to be $4,090 per capita, compared with $2,050 (US) spent by Canadians ... [For that] Americans recieve neither more hospital care nor more physciain services, althought they pay a lot more for the care they do receive. Americans do not receive higher quality care for their money; follow-up studies of patients on both sides of the border usually show similar outcomes.

Bob Evans. *What's right about the Canadian Health Care System*, 1999.

How much is enough?

Knowing how much to spend is not easy. The health of individuals and populations is influenced by many factors. Education, income, environment, employment status, genetics, and lifestyle behaviours – all have a bearing on health and health status.

As health care is but one of the factors, there appears to be no direct link between spending on health services and better health. For example, the United States spends far more per person on health care than any other country in the world. Yet overall health in the U.S. – measured by statistics like life expectancy and infant mortality – is lower than in countries like Canada and Britain, which spend less. While spending more money on health care makes a difference, at some point spending more will not lead to better health. In fact, if spending more in health services means spending less on education, protecting the environment or housing, the health of the population is likely to suffer

Increasing Costs

During the 1980's the growth in provincial government health spending in Saskatchewan far exceeded the growth in the economy. Increases in health spending contributed in part, to the deficits of the 1980s and added to the challenge of balancing the budget in the 1990s. Health spending was curtailed as part of the efforts to balance the budget, and began to rise again by the mid-nineties.

In the mid 1990s, some health districts balanced their budget by finding ways to reduce spending or at least moderate the rate of growth in spending. Other districts chose to run down their accumulated reserves. However, in the last few years this latter option is less and less available and some districts have run deficits. This means that the actual costs of public health programs are somewhat higher than the funding provided.

In recent years, health spending by the provincial government has grown faster than other government programs. In 1997, Saskatchewan ranked second, behind only Ontario, in the percentage of operating expenditures going to health care (37 per cent). This proportion has been steadily increasing.

On the other hand, health spending has not kept pace with growth in the economy as measured by Gross Domestic Product. In 1994 Canada spent approximately 9.8% of GDP on health, in 1997 the figure was closer to 9.2%. Similar figures apply to Saskatchewan.

Cost Factors

Why have health costs increased? First, any overall increase in the size of the population does, by definition, mean higher levels of spending on health care. Second, the cost of health services has gone up. other words, the price or costs of the same services is higher due to higher labour costs and inflation. Finally, each person is consuming, on average, more health services. New drugs and technologies are coming into the market at an ever-increasing rate that can only be expected to grow with advances in human genetics, robotics and other frontiers of knowledge. Not only are new discoveries increasing, so is the exchange of information. Consumers are getting information on potential new drugs and treatments from the media or the Internet, often before they are approved or made available.

Factors contributing to increasing health care costs				
	Population Growth (Per cent)	Growth in use of services (Per cent)	Rise in cost of health services (Per cent)	Growth in total spending (Per cent)
1975 to 1980	1.2	2.1	9.2	12.8
1980 to 1985	1.1	2.4	8.5	12.3
1985 to 1990	1.4	2.7	4.6	8.9
1990 to 1995	1.3	0.2	2.5	4.0

Source: Canadian Institute for Health Information, 1997.

Public and Private spending

Public sector spending on health includes several components. The vast majority of public spending is provincial health funding. The rest is spending by the Workers Compensation Board, Saskatchewan Government Insurance and other public agencies, and direct federal government spending on health services for First Nations people, armed forces personnel, and veterans. Private spending includes the user's portion of cost-shared services like nursing homes and prescription drugs, as well as privately paid services like dental care and the cost of private insurance. Total spending on health includes both public and private sources.

Saskatchewan ranks third among provinces in public sector health spending per person.

Per person health care spending from all public sources 1997		
Province	Per capita expenditures	Rank
Ontario	1,818	5
British Columbia	1,990	1
Manitoba	1,976	2
Saskatchewan	1,972	3
Alberta	1,792	6
Canada	**1,802**	

Source: Canadian Institute for Health Information, 1999.

For Canada as a whole, the public sector share of total health spending has declined from 76 per cent in 1975 to 69 per cent in 1997. However, the public sector share in Saskatchewan has remained nearly unchanged over that time and is higher than the Canadian average.

Public sector share of total health spending		
	1975 (per cent)	1997 (per cent)
Alberta	76.9	68.8
Saskatchewan	74.8	74.3
Manitoba	77.7	73.3
British Columbia	71.9	73.0
Ontario	75.4	66.2
Canada	**76.4**	**69.4**

Source: Canadian Institute for Health Information, 1999.

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Source: Canadian Institute for Health Information, 1999.

Provincial government health spending and revenues

Provincial government health spending has grown by $573 million (36.8 per cent) in the last five years – an average annual increase of about 7 per cent. Salaries and wages in the health sector have grown faster than other wages; costs of the Prescription Drug Plan have grown about 10 per cent per year.

Did you know?

Rate of growth of health spending by the Government of Saskatchewan over the past 5 years:
7% per year

Approximate rate of growth in revenues for the Government of Saskatchewan over the next 3 years:
1.2% per year

Source: Saskatchewan Finance

According to one estimate recently prepared for the provincial and territorial Ministers of Health, the cost of existing health programs are projected to increase *at least* 3.4 per cent a year over the next five years. This does not include any improvements in service that might be called for. More importantly, this projection is a minimum amount based on the effects population growth and inflation. The rate of growth may be much higher, factoring in new drugs and treatments, and spending on information technologies. Health spending may also need to grow faster if we are to repair or replace some of the aging buildings used to deliver health care as well as aging medical equipment, expenditures deferred in the 1990s. Recently announced federal funding for equipment will only help so much.

Therefore, unless changes are made, to deliver the current volume and scope of health care services spending on health in Saskatchewan would need to grow more than 3.4 percent each year. Yet government revenues available for health, education, highways and other programs are expected to grow at only about 1.2 per cent per year. The challenge for Saskatchewan is how to pay for rising health costs without sacrificing other priorities. Even with more funding from Ottawa, there will be tough decisions to make. Can growing costs be contained? If more money is required, where should it come from?

What has been suggested:

Some people suggest **reducing government funding** for certain health programs. This could mean increasing the portion of costs paid for privately. Others would argue that health is our most important social program and call for **increasing the proportion of spending on health** by reducing funding to other government services.

Some say that **premiums or user fees** would make people more responsible for the services they use. Others prefer **paying from general taxes**, saying premiums are just another kind of tax, and user fees prevent some people from seeking the care they need.

Provincial and Federal governments have agreed on **increased federal funding**. Many question whether the recent agreement adds enough money. Some say governments must **raise taxes** and spend more on health. Others say even with more money, **fundamental change in service delivery** is needed.

To bring spending in line with revenues, some call for **reducing administration staff**. Others point out that administration is a small proportion of costs, and real savings would require **closing facilities** or **changing the way health care providers work together**. Still others say that there are more than enough funds to cover useful new drugs and more home care, if we **cut out the waste of unnecessary tests, procedures and prescriptions**.

What do you think? Can you identify other options? It may also help to think about some of the following questions.

1. How should the people of Saskatchewan respond to increasing health costs – increase taxes, direct money from other programs (education, roads, agriculture?) or limit how big a share of the budget goes to health care and allow more health costs to be paid for privately?

2. Are there services currently paid for with tax dollars that could and should be paid for by individuals? Are there services currently paid for privately that can and should be paid by government?

3. To what extent is there duplication and inefficiency in the health system? In addition to the ongoing possibility for saving on administration costs, are there ways in which services can be made more efficient while ensuring quality?

4. To what extent can investments in disease and injury prevention, health protection and promotion today lead to better health and more manageable costs in the future?

Caring For Medicare

What Do You Think?

Please take a few minutes to fill out and return this short survey. If you have additional thoughts, please send those along with your responses to these questions.

When the questionnaire is complete you may:

- **Mail it to the Commission on Medicare in the envelope provided;**
- **Visit our website and complete the questionnaire online: www.medicare-commission.com.**
- **Call our toll-free number and provide your responses over the phone. 1-877-494-4844**

For more information, or additional print copies of the questionnaire, contact the Commission by mail, website or phone.

Commission on Medicare

Kenneth J. Fyke, Commissioner

CHALLENGE #1

Everyday Health

1. Below are two different views about how to make sure that people get everyday health services when they need them. Please put a checkmark beside the view that is closest to your own:

☐ We should keep hospitals open in as many communities as we can.

☐ We could have fewer hospitals if there were more ambulances and more trained ambulance staff available, and people could get hospital care in larger centres when needed.

☐ Other suggestion _____

2. Delivering care through Primary Health Services teams is another idea for everyday health care. These teams would include nurse practitioners, physicians, nutritionists, pharmacists, therapists and others, working together. Some team members could serve more than one community. Services would be on call 24 hours a day, seven days a week.

In general, do you think the Primary Health Services team approach would be positive or negative for the quality of health services you receive?

☐ Positive ☐ Negative ☐ Unsure

☐ Other _____

CHALLENGE #2

Specialized Care

1. Below are two different views about how to make sure that Saskatchewan people receive the best specialized health services, such as MRI tests or surgery. Please put a checkmark beside the view that is closest to your own:

☐ We should emphasise convenience by making these services available in a larger number of mid-sized communities across the province.

☐ To ensure the highest quality, we should concentrate specialized services in Regina, Saskatoon and three or four regional centres, even if it means some people have to travel farther to receive services.

☐ Other suggestion _____

2. How do you think waiting lists could be reduced? Please put a checkmark beside the option you think would be the most effective:

☐ Spend more money for new equipment, beds and operating rooms.

☐ Spend more money to recruit and retain specialist physicians and nurses.

☐ Make sure we're providing surgeries and tests only when necessary, by working with health professionals to develop guidelines for care based on scientific research.

☐ Other suggestion _____

CHALLENGE #3

Making Things Fair

1. Below are two different points of view about the health care system. Please put a checkmark beside the view that is closest to your own:

☐ It is the job of the health system to focus only on the treatment of disease, illness and injury.

☐ It is the job of the health system to do more than treat disease, illness and injury, and also promote health through things like improved parenting skills, better nutrition and helping people to quit smoking.

☐ Other suggestion _____

2. Below are two opposing statements about what the health system should do to meet the health needs of certain groups in our province. Please put a checkmark beside the view closest to your own.

☐ The health system should make a special effort to reach out to senior citizens, and poor families, because they often face higher health risks, and may not always get the health care they need.

☐ The health system should focus only on helping individuals when they seek health care services.

☐ Other suggestion _____

CHALLENGE #4

Getting Results

1. Below are two different views about how to ensure delivery of high quality health care in Saskatchewan. Please put a checkmark beside the view that is closest to your own.

☐ We should rely only on the judgement and independence of health care providers to make health care decisions.

☐ We should ensure that decisions made by health care providers are supported by the best research evidence.

☐ Other suggestion _____

2. Below are two views about the introduction of new drugs and medical procedures. Please put a checkmark beside the view that is closest to your own:

☐ Even if it means that some new technologies, procedures or drugs are not available, we should carefully examine the medical evidence and adopt only those that offer a clear improvement over other available solutions.

☐ Even if it means we have to pay more for health care, it is important that all new procedures, drugs, and technologies are made available in Saskatchewan as soon as they are approved.

☐ Other suggestion _____

CHALLENGE #5

Thank You

Your ideas will help the Commission on Medicare understand the issues and develop the best possible recommendations.

Paying the Bills

1. The provincial government currently spends about $2 billion a year on health, which is nearly 40% of total spending on programs and services. To determine the right level of health spending, should we

☐ Maintain spending at no more than the current 40% of the budget, which could mean that there's not enough money to cover increasing costs of existing health services.

☐ Match spending increases to the rate of growth in the provincial economy, which could mean higher taxes.

☐ Keep spending generally in line with other Canadian provinces.

☐ Other suggestion _____

2. If more money is required for the health care system, where do you believe this extra money should come from?

☐ An increase in taxes.

☐ Cuts to other government programs (For example, Education, Agriculture, Highways).

☐ Let individuals pay for more themselves.

☐ Other suggestion _____

3. Having thought about the information in this document, and based on your own experience, which of the following three general directions do you support for the future of Saskatchewan's health care system? Please put a checkmark beside the view that is closest to your own:

☐ Most problems that exist within the health care system can be fixed if the provincial government puts more money into health care.

☐ Changes are needed in the way the health system is organized, but the principles of Medicare should be preserved.

☐ It is time to move toward a private health care system, which allows people to buy the services they need and want, when the public system cannot meet those needs or wants.

☐ Other suggestion _____

Please Provide the Following Information:

Circle one: Male Female

Circle one age: 17 or under 18 –34 35 –54 55 –74 75 or older

Enter your postal code: _____

☐ Check if you work in health services.

APPENDIX A:

Commission on Medicare Mandate and Terms of Reference

Values

The people and the Government of Saskatchewan share a profound commitment to a publicly funded, publicly administered health system. In particular, Saskatchewan is committed to a health system that:

- Embodies the principles of *The Canada Health Act*: Universality, Portability, Accessibility, Comprehensiveness and Public Administration;
- Promotes the collective good and overall health and well being of the populati
- Provides a high standard of quality in the services provided;
- Treats people in a caring and compassionate manner;
- Clearly defines accountability and responsibility;
- Distributes costs in a way that is fair and equitable;
- Ensures access to services based on health need and not on the ability to pay;
- Uses public resources effectively.

Mandate

The Commission on Medicare will provide recommendations to the people and the government on the continuation of publicly funded, publicly administered Medicare in a manner that responds to the unique needs of Saskatchewan people, contributes to improved health and well being, and will be sustainable and affordable to citizens over the long term. Within this context, the Commission on Medicare has a three-fold mandate:

1. To identify key challenges facing the people of Saskatchewan in reforming and improving Medicare, including but not limited to:
    - improving an accessible, equitable, quality health system that serves the collective good of all residents of Saskatchewan;

- understanding the effect of changing populations on future health service needs;
- identifying financial challenges; and
- considering the supply and roles of health care providers.

2. To recommend an action plan for delivery of health services across Saskatchewan through a model that is sustainable and embodies the core values of Medicare. This action plan will:
   - describe what services are needed, how and where to deliver them, taking into account the health needs of citizens;
   - balance and integrate services (i.e., prevention and treatment, institutional and community-based care) to improve the health and well being of Saskatchewan residents; and
   - consider the share of public spending allocated to the health system relative to other program priorities and health spending as a percentage of the provincial gross domestic product (GDP);

3. To investigate and make recommendations to ensure the long-term stewardship of a publicly funded, publicly administered Medicare system. These recommendations should ensure that we:
   - have an accessible, quality health system for all;
   - consider the appropriate criteria for services to be publicly funded and administered into the future;
   - understand the need to balance health spending with other areas of public investment; and,
   - consider the balance between health services and other underlying factors that contribute to the health of individuals.

So that the people of Saskatchewan have an opportunity to participate in the Commission's work, the Commission shall solicit comment and information from the public and health sector stakeholders.

The Commission will provide the first of its reports to the Premier in the Fall of 2000 on the challenges facing the people of Saskatchewan in reforming and improving Medicare. The Commission will provide a second report to the Premier before the end of 2000 with an action plan for delivery of health services across Saskatchewan, and will provide a final report by the Spring of 2001 on the long-term stewardship of our publicly funded, publicly administered Medicare system.

APPENDIX B:

List of References:

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